

FY 2005 Claims Payment Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11201	Perform EDI Oversight	<p>The costs related to the establishment of EDI authorizations, monitoring of performance, and support of EDI trading partners to assure effective operation of EDI processes for electronic billing, remittance advice, eligibility query, claims status query, and other purposes; and/or between Medicare and a bank for electronic funds transfer or remittance advice.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual – Medicare Claims Processing Manual Chapters 22, 24, 25, 26 and 31 CRs amending the IOM: CR 2819-Ch. 24/Section 40.7 CR 2966-Ch. 24/Section 90 CR 3017-Ch. 31/Section 20.7 CR 3050-Ch. 24/Section 40.7.2 Joint Signature Memo (RO-2323, 10-19-03) 	<p>a. Obtain valid EDI and EFT agreements, provider authorizations for third party representation for EDI, and network service agreements. Enter the data into the appropriate provider-specific and security files, and process reported changes involving those agreements and authorizations.</p> <p>b. Issue/control/update/monitor passwords and EDI billing/inquiry account numbers</p> <p>c. Sponsor providers and vendors to establish IVANS, other private network, and LU 6.2 connections where supported</p> <p>d. Systems test with electronic providers/agents to assure compatibility for the successful exchange of data</p> <p>e. Submit EDI data, HIPAA implementation status, and submitter HIPAA testing status reports</p> <p>f. Monitor and analyze recurring EDI submission and receipt errors, and coordinate with the submitters and receivers when necessary to eliminate errors</p> <p>g. Investigate high provider eligibility query to claim ratios and initiate corrective action as needed</p> <p>h. Maintain a list on your web page of software vendors whose EDI software has successfully tested for submission of transactions to Medicare</p> <p>i. Furnish support to providers on the use of the free/low cost billing software</p> <p>j. Furnish basic support to providers on interpretation of transactions issued by Medicare</p>	

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11202	Manage Paper Bills/Claims	<p>All costs related to the receipt, control, and entry of paper claims and for maintenance of the standard paper remittance advice format. This activity encompasses tasks prior to and following the shared system process.</p> <p>Reference:</p> <ul style="list-style-type: none"> Medicare Claims Processing Manual, Chap 1, Section 40.4.1, 50, 50.1.1, 50.1.8, 50.2, 80, 80.1, 80.2.1, 130, 130.1. Chap. 22, Sections 10, 20, 30, 50, 50.2, Chap. 24, Sections 40.3.2, 40.4, Chap. 25, Section 50.1 	<p>a. Receive, open, sort and distribute incoming claims</p> <p>b. Image paper claims and attachments</p> <p>c. Assign control numbers and date of receipt</p> <p>d. Perform data entry (whether manual or electronic scanning)</p> <p>e. Identify claims that cannot be processed due to incomplete information</p> <p>f. Resolve field edit errors</p> <p>g. Return incomplete paper claims or paper claims that failed pre-shared system edits to providers for correction and resubmission</p> <p>h. Re-enter corrected/developed paper claims. Manage paper bills.</p> <p>i. Update the standard paper remittance advice format annually, if directed by CMS</p>	<p>Workload 1 is the difference between the total claims reported on the HCFA-1565, Page 9, Line 38, Column 1 minus the EMC claims reported in Line 38, Column 6.</p>
11203	Manage EDI Bills/Claims	<p>Establish, maintain, and operate the infrastructure for EDI and DDE, as supported, for claims, remittance advice, status query, eligibility query, and EFT. Requires 1 upgrade per year in each of the EDI formats supported, free billing software, and related tasks.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual- Medicare Claims Processing Manual Chapters 22, 24, 25, 26 and 31 	<p>a. Provide free billing software, PC-Print software (for pre-HIPAA versions/formats), and update once per year</p> <p>b. Alpha test and validate the free billing software</p> <p>c. Assist with resolution of problems with telecomm protocols and lines, and your software and hardware to maintain connectivity with partners</p> <p>d. Maintain capability for receipt and issuance of transactions via DDE, where supported, and in EDI batches</p> <p>e. Maintain EDI access, syntax, and semantic edits at the front-end, prior to shared system processing</p> <p>f. Route edit and exception messages, claim acknowledgements, claim development messages, and electronic remittance advice and query response transactions to providers/agents via direct transmission or via deposit to an electronic mailbox for downloading by the trading partners and route EFTs</p> <p>g. Maintain back-end edits to assure remittance advices 835 and 277 query responses comply with the implementation guide</p>	<p>Workload 1 is reported on the HCFA-1565, Page 9, Line 38, Column 6.</p>

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		<ul style="list-style-type: none"> Activity related CRs: CR 2840/Ch. 24 CR 2900/837P CD Modification CR 2947/835 CD/FF Modification CR 2948/835 CD Modification CR 2964/Ch. 24 CR 3065/Ch. 31 CR 3095/Ch. 24/Section 40.73 Ch. 3101/Ch. 24/Section 70.1 & 70.2 	requirements, and EFTs comply with the ACH or 835 requirements h. Create a copy of EDI claims as received and have the ability to recreate outgoing remittance advice and COB transactions i. Maintain audit trails to document processing of EDI transactions j. Translate transaction data between pre-HIPAA and HIPAA standard formats and the corresponding shared system flat files k. Update claim status and category codes, claim adjustment reason codes, and remittance advice remark codes l. Bill third parties for electronic access to beneficiary eligibility data, maintain receivables for those accounts, and terminate third parties for non-payment	
11204	Bills/Claims Determination	<p>Most of the costs related to the determination of whether or not to pay a claim after claim entry and initial field edits are automated and captured under the Run Systems activity. However, operational support staff is required to support claims pricing and payment in conjunction with the programming activities included under Run Systems. Costs of these support activities, which include the creation, maintenance, and oversight of reasonable charge screens, fee schedules, and other pricing determination mechanisms that support claims processing systems, are reported under the Bills/Claims Determination</p>	a. Maintain fee schedule (local variations) b. Check for duplicates c. Identify claims that have to be resolved manually d. Re-enter corrected/developed claims that suspend from the standard system e. Resolve edits on claims that cannot be processed (if possible) f. Maintain pricing software modules g. Update HCPCS, diagnostic codes, and other code sets that impact pricing as needed	Workload 1 for adjudicated claims is the difference between the cumulative numbers of claims processed reported on the HCFA-1565, Page 1, Line 15, Column 1 minus Line 16, Column 1 (replicates).

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		<p>activity. Also, the cost of any staff intervention in the adjudication of claims resulting from automated claims payment edits should be assigned to this activity.</p> <p>Reference:</p> <ul style="list-style-type: none"> • MCM, Part 2, Section 5240 • MCM, Part 3, Section 3000-4000 • MCM, Part 3, Section 4630 • PM B-01-60 		

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11205	Run Systems	<p>The costs of procurements and the programmer/management staff time associated with the systems support of claims processing outside those provided by the standard system maintainer under direct contract to CMS. It also includes, but is not limited to: data center costs for Bills/Claims Payment; local CPU costs for claims processing; validating new software releases; maintaining interfaces and testing data exchanges with standard systems, CWF, HDC, State Medicaid Agencies; maintaining the Print Mail function, on-line systems, telecommunications systems, and mainframe hardware; providing LAN/WAN support; and ongoing costs of transmitting claims data to and from the CWF host, as well as other telecommunications costs.</p> <p>Reference:</p> <ul style="list-style-type: none"> • MCM, Part 2, Section 5240 • MCM, Part 3, Sections 3000-4000 	<p>a. Test releases</p> <p>b. Assign Data Center costs</p> <p>c. Purchase software/hardware.</p> <p>d. Generate data for MSNs/EOMBs/NOUs, paper remittance advices, and paper checks (<i>Note: any associated printing and mailing costs will be included in the "Manage Outgoing Mail" activity</i>)</p> <p>e. Manage change requests</p>	

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11206	Manage IS Security Program	<p>The costs necessary to adhere to the CMS information systems security policies, procedures and core security requirements, re: the CMS Business Partner Systems Security Manual (BPSSM).</p> <p>Reference:</p> <ul style="list-style-type: none"> • BPSSM Section 2.2 • BPSSM Section 3.1 • BPSSM Section 3.2 • BPSSM Section 3.3 • BPSSM Section 3.4 • BPSSM Section 3.5.1 • BPSSM Section 3.5.2 • BPSSM Section 3.6 • BPSSM Section 3.7 • BPSSM Section 3.8 	<p>a. Principal Systems Security Officer (PSSO) staffing (including support staff), and training and supporting PSSO functions and responsibilities (Section 2 of the BPSSM)</p> <p>b. Conduct an annual self-assessment using CAST (A-2 of the BPSSM)</p> <p>c. Develop, review and update the systems security plans (Section 3.1 of the BPSSM)</p> <p>d. Conduct, review and update the Information System Risk Assessment (Section 3.2 of the BPSSM)</p> <p>e. Prepare the annual systems security component of internal control certification (Section 3.3 of the BPSSM)</p> <p>f. Prepare, review, update and test the information technology systems contingency plan (Section 3.4 of the BPSSM)</p> <p>g. Conduct an Annual Compliance Audit and implement Corrective Action Plans to resolve resultant findings (Section 3.5 of the BPSSM)</p> <p>h. Develop Computer Incident Reporting and Response Procedures (Section 3.6 of the BPSSM)</p> <p>i. Develop and maintain a system security profile (Section 3.7 of the BPSSM)</p>	

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11207	Perform Coordination of Benefits Activities with the Coordination of Benefits Contractor (COBC), Supplemental Payers, and States	<p>The costs associated with the continuation of activities related to the crossing over of Medicare processed claims data to existing trading partners and costs associated with the transmission of Medicare processed claims to the COBC.</p> <p>Reference:</p> <ul style="list-style-type: none"> Pub. 100-04, Section 70.6, Chapter 28 	<p>a. Maintain and support your existing Trading Partner Agreements (TPAs) during transition to the COBA process, including providing assistance to the trading partner as it cancels its TPA and coordinates its COBA implementation to avoid loss of crossed claims.</p> <p>b. Coordinate with the COBC to ensure that 837 flat file transmission issues, including transmission problems, data quality problems, and other technical difficulties, are resolved timely.</p> <p>c. Upon issuance of a CMS program transmittal, coordinate with the COBC to ensure that COBA trading partner requests for retrospective claims (COBA recovery process) are processed timely.</p> <p>d. Continue claim-based Medigap and/or Medicaid crossover processes until CMS issues a program transmittal that provides direction to cease such activities</p>	<p>Workload 1 is the number of claims transferred as designated in the MCM Pub. 100-06 (IER and FACP reporting).</p> <p>Workload 2 is the number of claims crossed to the COBC. (IER and FACP reporting).</p>
11208	Conduct Quality Assurance	<p>The costs related to routine quality control techniques used to measure the competency and performance of claims processing personnel; quality assurance reviews of fee schedules, HCPCS and ICD-9 updates and maintenance; and review of contractor systems.</p> <p>Misc. Code: 11208/01 – Part B Quality Assurance Reviews – Identify the amount included in Activity Code 11208 that is being requested for the new Part B Quality Assurance Process for completing the 1,000 case sample review.</p>	<p>a. Review suspended/reopened claims for correct processing</p> <p>b. Review processed paper/EMC claims for accuracy</p> <p>c. Perform other QC sampling techniques for claims processing</p> <p>d. Perform QA on fee schedules maintenance and contractor systems</p>	

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		Reference: <ul style="list-style-type: none"> • MCM, Part 1, Section 4213 • MCM, Part 2, Chapter 3, Section 5240 • MCM, Part 3, Sections 7032.3 • MCM, Part 3; Section 13360.1 • MCM, Part 3, Section 14002 • MCM, Part 3, Section 15023 		
11209	Manage Outgoing Mail	<p>The costs to manage the outgoing mail operations for the bills/claims processing function (e.g., costs for postage, printing NOUs/MSNs/EOMBs, remittance advices and checks, and paper stock).</p> <p>Reference:</p> <ul style="list-style-type: none"> • Medicare Claims Processing Manual, Chap 1, Section 20 • Medicare Claims Processing Manual Chap. 22, Section 10. 	<p>a. Mail NOUs/MSNs/ EOMBs, paper remittance advices, and checks</p> <p>b. Mail requests for information (other than medical records or MSP) to complete claims adjudication</p> <p>c. Return unprocessable claims to providers</p> <p>d. Return misdirected claims</p> <p>e. Forward misdirected mail</p>	

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11210	Reopen Bills/Claims	<p>The costs related to the post-adjudicative reevaluation of an initial or revised claim determination in response to (e.g.) the addition of new and material evidence not readily available at the time of determination; the determination of fraud; the identification of a math or computational error, inaccurate coding, input error, misapplication of reasonable charge profiles and screens, etc. <i>(Note: Include the cost of processing an adjustment, but only if the adjustment is specifically related to a reopening. Do not include the cost of an adjustment to a claim that results from an appeal decision).</i></p> <p>Reference: Internet Only Manual- Publication 100-4, Chapter 29, Section 60.27</p>	<ul style="list-style-type: none"> a. Receive written inquiry or referral for reopening b. Control and image claim c. Research validity of issues related to the reopening d. Adjust claim as appropriate e. Issue response related to claims determination if necessary (e.g., a revised NOU or EOMB) f. Refer to other areas if appropriate to the circumstances g. Document and maintain files for appropriate retrieval 	
11211	Non-MSP Carrier Debt Collection/Referral	<p>The costs incurred in the recovery of all Part B Program Management overpayments by carriers in accordance with applicable laws and regulations. <i>(Note: the costs of <u>developing</u> an overpayment should be captured in the respective budget area from which it was generated).</i></p>	<ul style="list-style-type: none"> a. Initiate the prompt suspension of payments to providers to assure proper recovery of program overpayment and reduce the risk of uncollectible accounts b. Verify bankruptcy information for accuracy and timeliness c. Coordinate with CMS/OGC and update the PSOR to ensure proper treatment and collection of overpayments d. Refer eligible debt to Treasury e. Review all extended repayment plan requests (ERPs) f. Coordinate with CMS on ERPs g. Documented attempts to collect overpayments timely. This 	

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		Reference: <ul style="list-style-type: none"> Medicare Financial Management Manual, Chapter 3 & 4 	includes attempting to locate providers and telephoning delinquent providers when necessary h. Assess systematic and manual interest on overpayments and underpayments correctly	

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12090	Part B Quality Improvement/ Data Analysis	<p>All costs associated with appeals quality improvement and data analysis.</p> <p>Reference:</p> <ul style="list-style-type: none"> PM AB-03-139 Medicare Claims Processing Manual, Chapter 29, §60.25 	<ol style="list-style-type: none"> Identify reasons for full or partial reversals and dismissals Identify denials due to medical review edits Identify providers/suppliers with high review rates and high reversals Identify problems/issues that have the highest rate of appeal or reversal Identify percentage of each level of appeal that result in full reversals, partial reversals, and affirmations Report on claims processing system errors, provider errors, and delayed documentation submission that result in denials and the potential affect on appeals requests Forward the results of data analysis and any recommendations to appropriate components (e.g. Medical Review, Provider Education, etc.) Take corrective action as needed Perform Quality Control Checks as instructed in the PM Create and maintain an effective system for internal feedback loops Submit reports to CMS as specified in official instructions 	
12141	Telephone Reviews/ Redeterminations	<p>All costs and workloads associated with conducting telephone reviews/redeterminations. Telephone reviews/redeterminations are those reviews/redeterminations that are requested by telephone and subsequently completed over the telephone.</p> <p>Misc. Code: 12141/01 – Dismissals/Withdrawals of Telephone Reviews/Redeterminations – All costs associated with processing telephone reviews/redeterminations that are dismissed or withdrawn.</p>	<ol style="list-style-type: none"> Take all pertinent information for review/redetermination request over the telephone Determine if the review/redetermination can be handled over the telephone Log Request into system and assign control number Enter data as necessary into system/database Conduct the review/redetermination over the telephone and evaluate evidence/case history Make a review/redetermination determination Write a review/redetermination determination letter (if wholly or partially unfavorable), if beneficiary initiated write a decision letter at appropriate reading level, issue an EOMB/MSN/RA (if wholly or partially favorable) Mail a review/redetermination decision letter to parties If decisions are partially or wholly reversed, effectuate decision 	<p>Workload 1 Telephone Review/ Redetermination Requests Cleared (claims) (CMS-2590, Line 7, Column 2)</p> <p>Workload 2 Telephone Review/ Redetermination Requests Cleared (cases) (CMS-2590, Line 6, Column 2)</p> <p>Workload 3 Telephone Review/</p>

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		Reference: <ul style="list-style-type: none"> Medicare Claims Processing Manual, Chapter 29, Sections 60.11, 60.12 CR 2620 	j. Enter case status information throughout the process of this activity and update as necessary	Redetermination Reversals (cases) (CMS-2590, Line 11, Column 2) Misc. Code Telephone Review/Redetermination Requests Dismissed or Withdrawn (Cases) (CMS-2590, Line 10, Column 2)
12142	Written Reviews/Redeterminations	<p>All costs and workloads associated with completing a written review/re-determination. Written reviews/re-determinations are those reviews/redeterminations that are requested by telephone or in writing and subsequently completed in writing.</p> <p>Misc. Code: 12142/01 – Dismissals/Withdrawals of Written Reviews/Redeterminations – All cost and workloads associated with processing written reviews/redeterminations that are dismissed or withdrawn.</p> <p>Reference:</p> <ul style="list-style-type: none"> §1869 and §1842(b)(2)(B)(i) of the Social Security Act 42 CFR 405.807 – 405.812 Medicare Claims Processing Manual, Chapter 29, Section 60.11, AB-03-133 Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 	a. Receive written review/redetermination request in corporate mailroom and date stamp request b. Assign contractor control number (CCN) to review/redetermination request c. Scan review/redetermination request and any other documentation, if applicable d. Forward review/redetermination request to appropriate department e. Begin review/redetermination case preparation and validate request f. Enter data as necessary into system/database g. Evaluate evidence and case history of review/redetermination request h. Obtain consultant/RN/specialist opinion for review/redetermination request, if necessary i. Write or call appellant to request additional documentation for the review/redetermination, if necessary j. Receive, scan and control additional documentation for review/redetermination, if necessary k. Make a determination about the review/redetermination request l. Write a review/redetermination determination letter (if wholly or partially unfavorable), if beneficiary initiated, write a decision letter at appropriate reading level, issue an EOMB/MSN/RA (if wholly or partially favorable) m. Mail review/redetermination determination letter to	<p>Workload 1 Written Review/Redetermination Requests Cleared (claims) (CMS-2590, Line 7, Column 1 minus Line 7, Column 2)</p> <p>Workload 2 Written Review/Redetermination Requests Cleared (cases) (CMS-2590 Line 6, Column 1 minus Line 6, Column 2)</p> <p>Workload 3 Written Review/Redetermination Reversals (Cases) (CMS 2590, Line 11, Column 1 minus Line 11, Column 2)</p> <p>Misc. Code Written Review/</p>

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		2000 <ul style="list-style-type: none"> Section 933 and 940 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 CR 2620 	parties, if applicable n. If decision is partially or wholly reversed, effectuate decision and update records o. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for possible HO Hearing Request	Redetermination Requests Dismissed or Withdrawn (cases) (CMS-2590, Line 10, Column 1 minus Line 10, column 2)
12143	Incomplete Review/Redetermination Requests	All costs and workloads associated with handling incomplete or unclear review/redetermination requests. Reference: <ul style="list-style-type: none"> Medicare Claims Processing Manual, Chap. 29, Section 60.11.1B CR 2620 	a. Receive unclear or incomplete request from provider or state b. Return it with clarification of what is required for a review/redetermination request c. Maintain a count of all review/redetermination requests that are returned and enter this count into CAFMII	Workload 2 Incomplete Review/Redetermination Requests Received (cases) (not currently captured on the CMS-2590).
12150	Part B Hearing Officer Hearings	All costs and workloads associated with processing, and conducting on-the-record, telephone, and in-person Hearing Officer (HO) Hearings. All costs and workloads associated with processing a dismissal/withdrawal of a Hearing request. Reference: <ul style="list-style-type: none"> § 1869 and §1842(b)(2)(B)(ii) of the Social Security Act 42 CFR 405.821 - 405.836 Medicare Claims Processing Manual, Chap. 29, Section 60.13, 	a. Receive HO hearing request in mailroom b. Assign contractor control number (CCN) to HO hearing request c. Scan HO hearing request and any other documentation, if applicable d. Forward HO hearing request to appropriate department e. Begin HO hearing case preparation and validate request f. Enter data as necessary into system/database g. Write and send a HO hearing acknowledgement letter h. Prepare the HO hearing case file i. Schedule the hearing j. Provide written notice of the hearing k. Pre-examine the HO hearing evidence l. Enter data as necessary into systems/database m. Examine the applicable sections of the statutes, regulations, rulings, policy statements, general instructions and formal guidelines to prepare for the HO hearing	Workload 1 HO Hearing Requests Cleared (claims) (CMS-2590, Line 7, Column 3) Workload 2 HO Hearing Requests Cleared (cases) (CMS-2590, Line 6, Column 3) Workload 3 HO Hearings Reversed (cases) (CMS-2590, Line 11, Column 3)

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		<p>60.14, 60.15, 60.16, 60.17, 60.18,</p> <ul style="list-style-type: none"> AB-03-133 	<p>n. Travel</p> <p>o. Conduct the HO Hearing</p> <p>p. Receive medical review for the HO hearing, if necessary</p> <p>q. Make a determination about HO hearing request</p> <p>r. Write and mail a HO hearing decision letter to appellant</p> <p>s. Effectuate the decision if whole or partial reversal</p> <p>t. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for possible ALJ request</p>	
12160	Part B ALJ Hearings	<p>All costs and workloads associated with the processing of ALJ hearing requests and effectuations.</p> <p>All costs associated with processing DAB referrals, DAB requests and DAB effectuations</p> <p>Reference:</p> <ul style="list-style-type: none"> 42 CFR 405.855 and 42 CFR 405.856 Medicare Claims Processing Manual, Chap. 29, Section 60.19, 60.19.4, 60.20, 60.21, 60.22AB-03-133 <p>Misc. Code: 12160/01 – Courier Service Fee – All costs of using a courier service to forward requests for Part B ALJ hearing and case files.</p>	<p>For Part B ALJ requests and effectuations</p> <p>a. Receive written ALJ hearing requests</p> <p>b. Assign contractor control number (CCN)</p> <p>c. Scan requests, referrals, and any other documentation, if applicable</p> <p>d. Forward ALJ hearing request to appropriate department</p> <p>e. Enter data as necessary into system/database</p> <p>f. Prepare and send an acknowledgement letter</p> <p>g. Assemble case file and make and maintain an exact copy of the file</p> <p>h. Forward case file to OHA</p> <p>i. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for potential future appeals</p> <p>j. Receive and control case file and decision</p> <p>k. Compute the amount due to the appellant/party based on the decision (if whole or partial reversal)</p> <p>l. Enter data as necessary into system/database</p> <p>m. Effectuate decision if whole or partial reversal</p> <p>n. Place documentation confirming payment has been made in the case file, if applicable</p> <p>For Part B DAB referrals, requests for case files and effectuations:</p> <p>a. Prepare draft Agency Referral memo and case file, and forward with original ALJ case file to lead RO within 30 days of the date of the ALJ decision</p> <p>b. Receive and control the appellant's DAB review request</p>	<p>Workload 1 ALJ Hearing Requests Forwarded (claims) (CMS-2590, Line 45, Column 1)</p> <p>Workload 2 ALJ Hearing Requests Forwarded (cases) (CMS-2590, Line 44, Column 1)</p> <p>Workload 3 ALJ Hearings Effectuated (cases) (CMS-2590, Line 58, Column 3)</p>

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			<p>or the DAB's request for a case file</p> <ul style="list-style-type: none"> c. Retrieve case file d. Copy any additional correspondence and make a copy of the original case file and maintain e. Send original case file to the DAB f. Effectuate DAB's decision g. Enter case status information throughout the process of this activity and update as necessary 	
12901	PM CERT Support	<p>All PM costs and workloads associated with supporting the Comprehensive Error Rate Testing (CERT) contractor.</p> <p>Reference:</p> <ul style="list-style-type: none"> • Program Integrity Manual (PIM) Chapter 12, Section 3.3.1 • PIM Chapter 12, Section 3.4 • PIM Chapter 12, Section 3.5 • PIM Chapter 12, Section 3.6.1 • PIM Chapter 12, Section 3.6.2 	<ul style="list-style-type: none"> a. Provide sample information to the CERT Contractor as described in Pub 100-8 Ch. 12 § 3.3.1A&B b. Ensure that the correct provider address is supplied to the CERT Contractor as described in Pub 100-8 Ch 12 § 3.3.1.C c. Research 'no resolution' cases as described in Pub 100-8 Ch 12 § 3.3.1.B d. Handle and track CERT-initiated overpayments/underpayments as described in Pub 100-8 Ch 12. § 3.4 and 3.6.1 e. Handle and track appeals of CERT-initiated denials as described in Pub 100-8 Ch 12. § 3.5 and 3.6.2 	

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13002	Beneficiary Written Inquiries	<p>All costs associated with answering beneficiary/Congressional questions through correspondence.</p> <p>All Costs associated with answering questions from beneficiaries visiting the Medicare Contractor facility.</p> <p>Reference:</p> <ul style="list-style-type: none"> Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 2 Section 20.2.1 	<p>a. Log/Control and stamp all written inquiries with receipt date in mailroom</p> <p>b. Answer Inquiry in writing, via telephone, or e-mail</p> <p>c. Send Response</p> <p>d. Maintain Quality Control Program for written policies and procedures</p> <p>e. Transfer misrouted correspondence</p> <p>f. Establish a correspondence Quality Control Program</p> <p>g. Perform continuous quality reviews of outgoing letters</p> <p>h. Answer visitors' questions courteously and responsively (formerly walk-in inquiries)</p>	<p>Workload 1 is the cumulative inquiries as reported on the CMS-1565, Line 27, Beneficiary Column.</p> <p>Workload 2 is the cumulative visitor inquiries (formerly walk-ins) as reported on the CMS-1565, Line 26, Beneficiary Column.</p>
13004	Customer Service Plans	<p>All costs associated with providing beneficiary outreach and educational seminars, conferences, and meetings for contractor's entire geographic area and not limited to the local RO.</p> <p>Reference:</p> <ul style="list-style-type: none"> Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 2, Section 20.5 	<p>a. Establish partnerships and collaborate with local and national coalitions and beneficiary counseling and assistance groups</p> <p>b. Provide service to areas with high concentrations of non-English speaking populations and for special populations such as: blind, deaf, disabled and any other vulnerable population of Medicare beneficiaries</p> <p>c. Conduct Medicare awareness training/education with appropriate Congressional staffs to resolve beneficiary issues with Medicare</p>	

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CAFM Code	Activity Name	Definition	Tasks	Workload
13005	Beneficiary Telephone Inquiries	<p>All costs associated with answering beneficiary/Congressional questions over the telephone.</p> <p>All costs associated with the monitoring of a Customer Service Representative's (CSRs) telephone skills and the accuracy of the response.</p> <p>All costs associated with planning/conducting training; and inputting/reviewing performance data.</p> <p>Reference:</p> <ul style="list-style-type: none"> Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 2, Section 20.1 	<p>a. Answer telephones</p> <p>b. Completing internal paperwork</p> <p>c. Inputting data into the system</p> <p>d. Analyzing reports and data</p> <p>e. Mailing information requested</p> <p>f. Making follow-up calls</p> <p>g. Monitoring Call</p> <p>h. Completing Scorecard</p> <p>i. Inputting Scorecard</p> <p>j. Reviewing Scorecard with CSR</p> <p>k. Planning/conducting training for CSRs</p> <p>i. Planning and deployment of NGD</p>	<p>Workload 1 is the cumulative inquiries as reported on the CMS-1565, Line 25, Beneficiary Column.</p>
13201	Second Level Screening of Complaints Alleging Fraud and Abuse	<p>Costs associated with screening second level beneficiary inquiries of potential fraud and abuse that are closed, ordering medical records for beneficiary inquiries that are closed and sending the referral package to the PSC or Medicare fee-for-service contractor BIU. This also includes the costs associated with the referral package for provider inquiries of potential fraud and abuse.</p> <p>Workload associated only with beneficiary.</p> <p>Misc. Code: 13201/01 - Second Level of Complaints Alleging Fraud and Abuse by Providers – Costs</p>	<p>a. Calls the beneficiary (CR 2719 & PIM Chapter 4, §4.6-4.6.2)</p> <p>b. Reviews claims history (CR 2719 & PIM Chapter 4, §4.6-4.6.2)</p> <p>c. Reviews provider correspondence files for educational/warning letters or contact reports that relate to similar complaints (CR 2719 & PIM Chapter 4, §4.6-4.6.2)</p> <p>d. Requests itemized billing statements, when necessary (CR 2719 & PIM Chapter 4, §4.6-4.6.2)</p> <p>e. Requests medical records, when necessary (CR 2719 & PIM Chapter 4, §4.6-4.6.2)</p> <p>f. Resolves complaints, whenever possible (CR 2719 & PIM Chapter 4, §4.6-4.6.2)</p>	<p>Workload 1 The total number of second level screening inquiries that were open or closed for beneficiaries.</p> <p>Workload 2 The total number of medical records ordered for beneficiary inquiries that were open or closed.</p> <p>Workload 3 The total number of potential fraud and abuse beneficiary complaints identified and referred to the PSC or Medicare BI unit.</p>

FY 2005 Beneficiary Inquiries Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		associated with the referral package for provider inquiries of potential fraud and abuse.	<ul style="list-style-type: none"> g. Refers complaints that are not fraud and abuse to the appropriate staff within the contractor or PSC, if appropriate (CR 2719 & PIM Chapter 4, §4.6-4.6.2) h. Screens all Harkin Grantee complaints for fraud and abuse and maintains the Harkin Grantee Database (CR 2719 & PIM Chapter 4, §4.6-4.6.2, §4.12.3-4.2.4) i. Compiles information in the Database into an aggregate report (PIM Chapter 4, §4.12.4) j. Distributes the aggregate report to the Harkin Grantee state project coordinator every 6 months and send copies of the report to CMS CO (PIM Chapter 4, §4.12.4) k. Screens all OIG Hotline complaints for fraud and abuse (CR 2719 & PIM Chapter 4, §4.6-4.6.2) l. Develops the referral package for the PSC or Medicare fee-for-service contractor BIU on fraud and abuse complaints (CR 2719 & PIM Chapter 4, §4.6-4.6.2) m. Refers the referral package to the PSC or Medicare fee-for-service contractor BIU 	

FY 2005 Provider Communications (PCOM – PM) Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
14101	Provider/Supplier Information and Education Website	<p>All costs associated with maintaining an Internet web site that is dedicated to furnishing providers and suppliers with timely, accessible and understandable Medicare program information. This includes the costs associated with the development and maintenance of an internet web site.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Section 30.1.7 	<p>a. Develop a website that is consistent with CMS requirements and website functionality</p> <p>b. Periodically review the Web site standards Guidelines for compliance</p>	<p>Workload 1 is the number of page views per month at the URL (root) level for your provider education web site.</p>
14102	Electronic Mailing Lists/List-servs	<p>All costs associated with the development and maintenance of electronic list-servs.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Section 30.1.7 	<p>a. Provide registrants via e-mail of important and time sensitive Medicare program information</p> <p>b. Notify registrants of the availability of contractor bulletins</p> <p>c. Ensure that list-serv accommodates all providers/suppliers</p>	<p>Workload 1 is the total number of contractor provider/supplier PCOM electronic mailing lists.</p> <p>Workload 2 is the total number of registrants on all the PCOM electronic mailing lists.</p> <p>Workload 3 is the number of times contractors have used their list-serv(s) to communicate with providers/suppliers.</p>

FY 2005 Participating Physician Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
15001	Participating Physicians	<p>Funding for the continuation of the Annual Participating Enrollment, Limiting Charge Monitoring Activities and Dissemination of Participation Information remains a priority for CMS for the 2005 fiscal year. All of these activities remain vital functions to the operating efficiency of this agency.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM Pub. 100-4, Chapter 1, Section 30.3.12.1 Transmittal 11, CR 2889 • IOM Pub. 100-6, Chapter 6, Section 390, 2005 BPR • IOM Pub. 100-4, Chapter 1 Section 30.3.12.3, 2005 BPR • Transmittal 11, CR 2889, 2005 BPR 	<p>Annual Participation Enrollment</p> <ol style="list-style-type: none"> For FY 2005, carriers will be instructed to furnish the participation enrollment material via a CD-ROM. Carriers that choose not to participate in the CD-ROM initiative must provide a written justification. The justification must provide a rationale for why the CD-ROM is not cost effective, why it is not efficient (e.g. printing in-house vs. out sourcing) and why it is not a better service for the providers. Carriers will also be instructed to prepare hardcopy disclosure material for at least two percent of their total number of providers. Produce and mail calendar year 2005 participation enrollment packages (consisting of the “Dear Doctor” Announcement, Blank Par Agreement, Fact Sheet and physician fee schedule disclosure report) via first class or equivalent mail delivery service. CMS is pursuing making available, via electronic access, CD-ROM development material created by one of the carriers that participated in the FY 2004 CD-ROM pilot. Process participation enrollments and withdrawals. Furnish participation data to RRB. Furnish participation data to CMS. <p>Limiting Charge Monitoring Activities</p> <ol style="list-style-type: none"> Investigate/develop beneficiary-initiated limiting charge violation complaints. Investigate/develop beneficiary-initiated limiting charge violation complaints. Respond to limiting charge inquiries from non-participating physicians. Internally produce and store limiting charge reports (e.g., LCERs/LCMRs) 	<p>Workload 1 is the number of participation enrollment packages mailed to providers at a national level.</p> <p>Workload 2 is the number of enrollments and withdrawals processed.</p> <p>Workload 3 is the number of limiting charge reports, violations and complaints processed.</p>

FY 2005 Participating Physician Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
			<p>e. Submit quarterly reports for internally produced limiting charge reports. (IOM Pub. 100-4, Chapter 1, Section 30.3).</p> <p>Disseminate Participation Information</p> <p>a. Furnish customized participation information (either by phone or in writing) in response to requests for such information.</p> <p>b. Discontinue the production and mass distribution of hardcopy MEDPARD directories.</p> <p>c. Load MEDPARD information on your Internet website and inform physicians, practitioners, suppliers, hospitals, Social Security Offices, Congressional Offices, QIOs, senior citizens groups and State area agencies of the Administration on Aging how to access this website information.</p>	

FY 2005 Provider/Supplier Enrollment Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks*	Workload
31001	Provider Enrollment	<p>Provider/supplier enrollment is a critical function to ensure only qualified and eligible individuals and entities are enrolled in the Medicare program. Physicians, non-physician practitioners and other healthcare suppliers must enroll with the Medicare Carriers, with whom they will do business, before receiving payment for services furnished to beneficiaries. Each applicant will use the appropriate enrollment form and undergo the entire enrollment process, including verification of their information.</p> <p>Reference:</p> <ul style="list-style-type: none"> PIM, Chapter 10* 	<p>a. Distribute all enrollment applications or refer the applicant to the CMS web site (§2.2)</p> <p>b. Process initial applications (CMS 855I and CMS 855B) from receipt to final decision, including verification and meeting the CMS timeliness standards (§1 - 5, 8, 9, 15 - 21, 25)</p> <p>c. Process, verify and acknowledge changes of information within the CMS timeliness standards (§3, 13)</p> <p>d. Process and verify reassignment of benefits requests, (CMS 855R) within the CMS timeliness standards (§7)</p> <p>e. Verify and document provider enrollment information using the FID, Qualifier.Net, etc. (§2.2)</p> <p>f. Image applications (i.e., for authorized representative and delegated official signatures) or maintain a hardcopy file to compare the signatures of the authorized representative and delegated official for changes to “pay-to” addresses (§2.2)</p> <p>g. Enter all new application information into the Provider Enrollment, Chain and Ownership System (PECOS) (§2.2)</p> <p>h. Ensure staff is trained on enrollment requirements, procedures and techniques (§2)</p> <p>i. Respond to all phone calls and miscellaneous letters concerning enrollment in the Medicare program. Provider enrollment-initiated educational projects should be charged to provider enrollment. Activities done in conjunction with the Provider Communications (PCOMM) group should be charged to the PCOMM line (§22)</p> <p>j. Provide a link to the CMS web site from your contractor web site (§23)</p> <p>k. Communicate with the UPIN Registry, to include review, update and corrections of records (§2)</p> <p>l. Initiate special projects as necessary or as requested by CMS</p>	<p>Workload 1 is the number of initial application requests (CMS 855B, CMS 855I) received in a month. The RMC workload will be the number of PECOS enrollment records flagged in a month.</p> <p>Workload 2 is the number of change of information requests (CMS 855I, CMS 855B) received in a month.</p> <p>Workload 3 is the number of Reassignment of Benefit requests (CMS 855R) received in a month.</p> <p>In order to capture processed and pending applications, carriers shall continue to report provider enrollment information on a weekly basis to their applicable consortia through the National Workload Summary Provider Enrollment Inventory (see example).</p>

FY 2005 Provider/Supplier Enrollment Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks*	Workload
			<p>m. Coordinate with other internal components (e.g., appeals, fraud unit, EFT processor, provider education/professional relations, ROs etc.). For EFTs, only charge provider enrollment for including the EFT form in the mailing of the new provider packet and the verification of the bank account (§2)</p> <p>n. Coordinate with other external components (e.g., OIG, Medicaid, FBI, Payment Safeguard Contractors (PSCs), etc.). When working with PSCs, the carrier will charge their assistance to a PSC under one of the three designated workloads (see activity code 23201). Work not associated with one of these workloads is charged to provider enrollment (§2)</p> <p>o. Perform site visits for IDTFs and other problematic suppliers, as needed (§18)</p> <p>p. Carriers will use the transitory database to move supplier information into PECOS when changes of information or reassignments occur.</p> <p>q. Carriers will budget for a full year of their current appeals process</p> <p>r. The RMC shall report monthly IER workloads where they are required to add their flag (or billing number) to PECOS to pay RMC claims.</p> <p>s. The RMC will add their flag (or billing number) to RECOS for payment of RMC claims.</p>	

FY 2005 Provider Inquiries Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
33001	Answering Provider Telephone Inquiries	<p>All costs associated with answering provider questions over the telephone.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub 100-9 Chapter 3 §20.1.1-20.1.5 IOM Pub 100-9 Chapter 3 §20.1.8-20.1.12 	<p>a. Answering the phones timely</p> <p>b. Completing internal paperwork</p> <p>c. Inputting data into the system</p> <p>d. Analyzing reports and data</p> <p>e. Sending requested information</p> <p>f. Making follow-up calls</p> <p>g. Implementing a provider satisfaction survey</p> <p>h. Developing a contingency plan</p> <p>i. Developing an IVR quality assurance plan</p> <p>j. All costs associated with purchasing and maintaining telephone systems and equipment</p>	Workload 1 is the cumulative inquiries as reported on the HCFA-1565, Line 25, Provider Column
33014	Provider Quality Call Monitoring	<p>All costs associated with the monitoring of a Customer Service Representative's (CSRs) telephone skills and the accuracy of the response.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub 100-9 Chapter 3 §20.1.7 	<p>a. Monitoring Calls</p> <p>b. Completing Scorecard</p> <p>c. Inputting Scorecard</p> <p>d. Reviewing Scorecard with CSR</p>	
33020	Staff Development and Training	<p>All costs associated with the training and development of provider inquiries staff.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub 100-9 Chapter 3 §20.1.6 	<p>a. Planning/conducting training for CSRs</p> <p>b. Attending CMS sponsored meetings, conferences and train-the-trainer sessions related to provider customer service</p>	

FY 2005 Provider Inquiries Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
33002	Provider Written Inquiries	<p>All costs associated with answering provider questions through written correspondence.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub 100-9 Chapter 3 §20.2 	<p>a. Logging/Controlling and date stamping all written inquiries in the mail room</p> <p>b. Responding to a written inquiry in writing, via telephone, or via e-mail</p> <p>c. Mailing the response (if applicable)</p> <p>d. Maintaining a Quality Control Program for written policies and procedures</p> <p>e. Transferring misrouted correspondence</p> <p>f. Maintaining a correspondence Quality Control Program</p> <p>g. Performing continuous quality reviews of outgoing letters</p>	<p>Workload 1 is the number of provider written inquiries received by the contractor as reported on the CMS-1565, Line 27, Provider Column.</p>
33003	Provider Walk-In Inquiries	<p>All costs associated with answering questions from providers visiting the Medicare Contractor facility.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub 100-9 Chapter 3 §20.3 	<p>a. Maintain sign-in sheets for walk-in individuals</p> <p>b. Keep records of contact by recording facts, questions, and responses given to individuals</p> <p>c. Conduct inquiry interview</p> <p>d. Provide Medicare publications, as required</p>	<p>Workload 1 is the cumulative inquiries as reported on the CMS-1565, Line 26, Provider Column.</p>

FY 2005 Medical Review Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
21001	Automated Review	<p>When medical review is automated, review decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. See IOM Pub. 100-8 Ch. 3 section 5.1 for further discussion of automated review.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM Pub. 100-8 Chapter 3, Section 3.4.5 (A) • IOM Pub. 100-8 Chapter 3, Section 3.5.1 • IOM Pub. 100-8 Chapter 11, Section 11.1.3.1 	<p>a. Develop edits b. Implement edits c. Generate denial letters if appropriate, <u>this does not include collecting the over payment</u></p>	<p>Workload 1 is the number of claims denied in whole or in part.</p> <p>Workload 2 to the extent that contractors can report claims subject to automated medical review.</p>
21002	Routine Reviews	<p>Routine review requires the intervention of specially trained non-clinical MR staff and is restricted to determinations which can be made by review of the claim, attachments which do not require clinical judgment, and review of claims history.</p> <p>NOTE: Report post pay routine review workload denied due to lack of documentation on the remarks section of 21002. Do not include these denials in any other workload of this activity code.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM Pub. 100-8 Chapter 3, Section 3.4.5 (B) • IOM Pub. 100-8 Chapter 11, Section 11.1.3.2 	<p>a. Develop edits b. Implement edits c. Perform quality assurance on edits d. Review claim e. Make determination f. Generate denial letter if appropriate, <u>this does not include collecting the over payment</u></p>	<p>Workload 1 is number of claims reviewed.</p> <p>Workload 2 is number claims denied in whole or in part.</p> <p>Workload 3 is the number of providers subjected to routine review, to the extent a contractor can report this.</p>

FY 2005 Medical Review Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
21007	Data Analysis	<p>Data Analysis is the integrated and on-going comparison of CERT findings, claim information, claims data deviations from standard practice, and other related data to identify potential provider or service billing practices that may pose a threat to the Medicare Trust fund. This analysis can be a comparison of individual claim characteristics or in the aggregate of claims submissions. Analysis of data will lead to the generation of a list of program vulnerabilities that the contractor will use to focus their education and review resources.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub. 100-8 Chapter 2, Section 2.2 IOM Pub. 100-8 Chapter 11, Section 11.1.4 	<p>a. Collect data b. Analyze and compare data c. Identify potential program vulnerabilities d. Institute ongoing monitoring and modification of data analysis program components e. Develop and maintain trend reports over at least an 18-month period</p>	
21206	Policy Reconsiderations and Revision Activities	<p>Contractors are to update Local Coverage Determinations (LCDs). Costs accrued for transitioning Local Medical Review Policy (LMRPs) to the LCD format should be captured here.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub. 100-8 Chapter 13, Section 13.4 IOM Pub. 100-8 Chapter 11, Section 1.5.2 	<p>a. Determine need (See IOM Pub. 100-8, CH. 13, §4) b. Develop draft LCD change c. Solicit comments d. Compile and respond to comments e. Develop final coverage determinations f. Distribute coverage determinations g. Post LCD on the database</p>	<p>Workload 1 reports the total number of policies/coverage determinations revised.</p> <p>Workload 2 reports the total number of policies/coverage determinations that required notice and comment.</p> <p>Workload 3 reports total number of policies/coverage determinations revised due to outside request (e.g., beneficiary or provider request).</p>

FY 2005 Medical Review Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
21207	MR Program Management	<p>MR Program Management encompasses managerial responsibilities inherent in managing the Medical Review (MR) and Local Provider Education & Training (LPET) Programs, including development, modification and periodic reports of MR/LPET Strategies and Quarterly Strategy Analysis (QSA); and quality assurance activities; planning, monitoring and adjusting workload performance; budget-related monitoring and reporting; and implementation of CMS instructions. Any MR activity required for support of a MR PSC should also be included in this code (this does not include MR to support the CERT contractor).</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub. 100-8 Chapter 11, Section 11.1.9 	<p>a. Review data from data analysis</p> <p>b. Develop and prioritize a problem list from the data analysis</p> <p>c. Determine the educational and review activities that will be used to address the problems on the problem list</p> <p>d. Develop and periodically modify Medical Review/LPET Strategy</p> <p>e. Track and modify problem list activities by using the QSA</p> <p>f. Develop and modify quality assurance activities, including special studies, Inter-Reviewer Reliability testing, Committee meetings, and periodic reports</p> <p>g. Evaluate edit effectiveness</p> <p>h. Plan, monitor, and oversee budget, including interactions with contractor budget staff and RO budget and MR program staff</p> <p>i. Manage workload, including monitoring of monthly workload reports, reallocation of staff resources, and shift in workload focus when indicated</p> <p>j. Implement Medical Review instruction from CMS</p> <p>k. Educate staff on Medical Review issues, new instructions, and quality assurance findings</p> <p>l. Support services for contractors that work with a PSC that performs MR activities</p>	

FY 2005 Medical Review Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
21208	New Policy Development Activities	<p>Contractors are to create Local Coverage Determinations (LCDs) in accordance with IOM 100-8 Chapter 13, Section 13.4..</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub. 100-8 Chapter 13, Section 13.4 IOM Pub. 100-8 Chapter 11, Section 11.1.5.1 	<p>a. Determine need (See IOM Pub. 100-8, Ch. 13, § 4 (A) for circumstances requiring a need for LCD development)</p> <p>b. Develop draft LCD</p> <p>c. Solicit comments</p> <p>d. Compile and respond to comments</p> <p>e. Develop final LCD</p> <p>f. Distribute LCD</p> <p>g. Post LCD on to the database</p>	<p>Workload 1 is the number of new LCDs that were presented for notice and comment.</p> <p>Workload 2 is the number of LCDs that became effective.</p>
21220	Complex Probe Review	<p>Report all costs associated with prepay and postpay Complex Probe Review. Prepay and postpay probe reviews are done to verify that the program vulnerability identified through data analysis actually exists and will require additional education and possible review.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub. 100-8, Chapter 3, Section 2 (A) IOM Pub. 100-8, Chapter 11, Section 11.1.7.4 	<p>a. Select sample</p> <p>b. Request medical records/additional information</p> <p>c. Review claim</p> <p>d. Make determination</p> <p>e. Generate denial/demand letters, if appropriate, <u>this does not include the collection of the overpayment</u></p>	<p>Workload 1 is the number of claims reviewed.</p> <p>Workload 2 is the number of claims denied in whole or in part.</p> <p>Workload 3 is the number of providers subjected to complex probe review.</p>
21221	Prepay Complex Review	<p>Report all costs associated with Prepay Complex Review. Prepay medical review of claims requires that a benefit category review, statutory exclusion review, reasonable and necessary review, and/or coding review be made BEFORE claim payment. Complex medical review involves using clinical judgment by a licensed medical professional to evaluate medical records. Only claims reviewed based on a medical review edit and were addressed in the MR/LPET strategy shall be allocated to this activity line.</p>	<p>a. Develop edits</p> <p>b. Implement edits</p> <p>c. Perform quality assurance of edits</p> <p>d. Request medical records and additional documents</p> <p>e. Review claim and documentation</p> <p>f. Make determination</p> <p>g. Generate denial letters, if appropriate, <u>this does not include the collection of the overpayment</u></p>	<p>Workload 1 is the number of claims reviewed.</p> <p>Workload 2 is the number of claims denied in whole or in part.</p> <p>Workload 3 is the number of providers subjected to complex review.</p>

FY 2005 Medical Review Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		<p>Misc. Code: 21221/01 (DMERCs Only) – Advance Determinations of Medicare Coverage (ADMC) – DMERCs are to report all costs associated with performing Advance Determinations of Medicare Coverage.</p> <p>DMERCs are to report the number of ADCMC requests accepted.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM Pub. 100-8 Chapter 3, Section 3.4 • IOM Pub. 100-8 Chapter 3, Section 3.4.5 • IOM Pub. 100-8 Chapter 5, Section 7 • IOM Pub. 100-8 Chapter 11, Section 11.1.3.3 		
21222	Postpay Complex Review	<p>Contractors must report all costs associated with Postpay Complex Review. Prepay medical review of claims requires that a benefit category review, statutory exclusion review, reasonable and necessary review, and/or coding review be made AFTER claim payment. These types of review give the contractor the opportunity to make a determination to pay a claim (in full or in part), deny payment or assess an overpayment. Complex medical review involves using clinical judgment by a licensed medical professional to evaluate medical records. Only claims reviewed based on a medical review edit and were addressed in the MR/LPET strategy shall be allocated to this activity line.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM Pub. 100-8 Chapter 3, Section 3.4 • IOM Pub. 100-8 Chapter 3, Section 3.4.5 • IOM Pub. 100-8 Chapter 11, Section 11.1.7.2 • IOM Pub. 100-8 Chapter 11, Section 11.1.7.3 	<p>a. Select claims</p> <p>b. Request medical records and additional documents</p> <p>c. Review claim and documentation</p> <p>d. Make determination</p> <p>e. Generate overpayment demand letters, if appropriate, <u>this does not include the collection of the overpayment</u></p>	<p>Workload 1 is the total number of claims reviewed on a postpayment basis.</p> <p>Workload 2 is the total number of claims denied in whole or in part.</p> <p>Workload 3 is the number of providers subjected to postpayment review.</p>

FY 2005 Medical Review Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		<ul style="list-style-type: none"> IOM Pub. 100-8 Chapter 11, Section 11.1.7.4 		
21901	MIP Comprehensive Error Rate (CERT) Support	<p>Report the costs associated with the time spent on activities to support the CERT contractor that are performed by the Medicare Integrity Program functional areas.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM Pub. 100-8 Chapter 12 	<p>a. Providing review information to the CERT Contractor as described in IOM Pub. 100-8 Ch. 12, § 3.3.2</p> <p>b. Providing feedback information to the CERT Contractor as described in IOM Pub. 100-8 Ch. 12, § 3.3.3, including but not limited to:</p> <ul style="list-style-type: none"> CMD discussions about CERT findings Participation in biweekly CERT conference calls Responding to inquiries from the CERT contractor Preparing dispute cases <p>c. Preparing the Error Rate Reduction Plan (ERRP) as described in IOM Pub. 100-8 Ch. 12, §3.9</p> <p>d. Educating the provider community about CERT as described in IOM Pub. 100-8 Ch. 12, §3.8</p> <p>e. Contacting non-responders and referring recalcitrant non-responders to the OIG as described in IOM Pub. 100-8 Ch. 12, § 3.15</p>	

FY 2005 Medicare Secondary Payer (MSP) Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
22001	MSP Bills/Claims Prepayment	<p>All costs of activities associated to continue processing of a MSP claim after it enters the claims processing system, subsequent to initial claim entry, and activities necessary to aid in the processing of MSP Prepay-related Congressional and hearings.</p> <p>Reference:</p> <ul style="list-style-type: none"> Medicare Secondary Payer Manual, Chapters: 3, 5, 6 & 7 	<p>a. Resolve MSP claim edits occurring in the claim adjudication process within the standard systems and in response to CWF verification and validation</p> <p>b. Compare EOB/RA data attached to the MSP claim to HIMR/CWF data to identify the presence/absence of a CWF MSP Aux File record and to continue claim processing</p> <p>c. Contact the provider (for clarification- not development) if necessary, to avoid suspending the claim</p> <p>d. Add termination dates to MSP auxiliary records previously established on CWF with a “Y” validity indicator when no discrepancy exists in the validity of the CWF information and an active claim (simple terminations)</p> <p>e. Prepare a CWF Assistance Request to terminate a record only when a system problem exists or it fits existing CWF error codes/subject to the 6-month rule</p> <p>f. Work MSP suspended claims that have not processed through to final payment decision including:</p> <p>g. Override a claim using conditional payment codes to process the claim as primary</p> <ul style="list-style-type: none"> -Prepare an “I” record to accommodate an override -Determine to pay as primary or secondary or deny -Follow up on COBC development/actions -Address CWF Automatic Notices <p>h. Complete MSP ECRS Inquiries and CWF Assistance Requests necessary to process the receipt of a claim through to payment or denial – Use C in the ECRS AC field.</p> <p>i. Follow up on prepay CWF Assistance Requests within designated timeframes</p> <p>j. Create “I” records when enough claim information exists to add a new CWF MSP Aux File record</p> <p>k. Process Congressional inquiries and hearings related to MSP Prepay functions and follow up with COBC within designated timeframes</p>	<p>Workload 1 is the number of MSP claim edits resolved in the claim adjudication and CWF verification and validation processes and the “I” records manually prepared, necessary to complete the processing of a claim.</p> <p>Workload 2 is the number of ECRS MSP Inquiries and CWF Assistance Requests transmitted to the COBC.</p> <p>Workload 3 is the number of MSP prepays Congressional and hearing requests processed, including follow up with the COBC.</p>

FY 2005 Medicare Secondary Payer (MSP) Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
42002	Liability, No-Fault, Workers' Compensation, Federal Tort Claim Act (FTCA)	<p>All costs of activities associated with the identification and establishment of a MSP Recovery claim specific to the named activity.</p> <p>Reference:</p> <ul style="list-style-type: none"> Medicare Secondary Payer Manual, Chapters: 2, 4, 5, 6 & 7 		
42003	Group Health Plan	<p>All costs of activities associated with identification and demand of all Medicare mistaken payments specific to the named activity.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual Pub. 100-5 Medicare Secondary Payer Manual, Chapters: 3 & 6 	<p>a. Install/run Data Match tapes</p> <p>b. Perform all Data Match and Non-Data Match history searches</p> <p>c. Develop & issue recovery demand letters (Data Match, Non-Data Match and DPP demands, as well as, demands resulting from 42 CFR 411.25 notices) taking into account existing search parameters and tolerances, if any</p> <p>d. Check CWF prior to mailing of recovery demands, if contractors' systems will not recognize an existing termination date on an MSP record, to ensure valid MSP periods</p> <p>e. Respond to any pre-demand Data Match & Non-Data Match incoming CORR related to a case</p> <p>f. Send copies of initial demand letters to the insurer/TPA of that employer (debtor)</p> <p>g. Perform all MPARTS status code updates related to actions up to and through the issuance of a recovery demand</p> <p>h. Perform appropriate case related ECRS transactions. Use G in the ECRS AC field</p>	<p>Workload 1 is the number of GHP recovery demand letters issued to the debtor (do not count the copy)</p> <p>Workload 2 is the number of MSP post payment case related ECRS transactions performed.</p>

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42004	MSP General Inquires	<p>All costs of activities associated to MSP CORR that is <u>not case or active claim specific</u>.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual Pub. 100-5 Medicare Secondary Payer Manual, Chapters 3, 5 & 6 	<p>a. Perform appropriate general (non-case related and non-active claim related) ECRS transactions, including those that may be necessary for voluntary refunds/unsolicited refunds. Use I in the ECRS AC field</p> <p>b. Take action on non-active claim and non-case related letters (including voluntary refunds/unsolicited refunds), faxes, e-mails, or telephone inquiries</p> <p>c. Respond to one time inquiries for outreach materials which may include the reproduction of these materials (those not counted in 42006)</p> <p>d. Enter non-case related and non-active claim related CWF termination dates</p> <p>e. Respond to OBRA 93 requests not related to an existing debt</p> <p>f. Perform only necessary clerical support for Appeals staff to make determinations</p>	<p>Workload 1 is the number of general MSP inquiries resolved. This includes OBRA 93 requests.</p> <p>Workload 2 is the number of non-case related & non-active claim related ECRS transactions performed specific to voluntary/unsolicited refunds</p> <p>Workload 3 is the number of one-time inquiries requesting outreach materials.</p>
42006	Outreach	<p>All cost of activities associated to the development and presentation of MSP material to or for target audiences</p>	<p>a. Develop and /or revise/update audience appropriate outreach materials of recovery and presentation, e.g. beneficiary/insurer/provider handout materials (booklets and brochures) and internet Web sites</p> <p>b. Develop training materials and perform outreach presentations</p> <p>c. Maintain and reproduce outreach materials as necessary</p> <p>d. Respond to written and phone request for outreach materials (Note: a onetime inquiry requesting outreach materials (which may /may not include reproduction of these materials should be reported under AC 42004-General Inquiries)</p>	<p>Workload 1 is the number of educational seminars, workshops, educational classes and /or face to face meetings.</p> <p>Workload 2 is the number of videos or brochures created and /or revised.</p> <p>Workload 3 is the number of changes/ updates or any new modules related to the WEB page and /or web based training modules.</p>

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CAFM Code	Activity Name	Definition	Tasks	Workload
42021	Debt Collection/Referral	<p>All costs of activities associated with the collection of all MSP debts and the referral of eligible delinquent MSP debt under the Debt Collection Act of 1996.</p> <p>Reference:</p> <ul style="list-style-type: none"> Internet Only Manual Pub. 100-5 Medicare Secondary Payer Manual, Chapters: 3, 5, 6 & 7 	<p>a. Ensure proper recovery of MSP debts</p> <p>b. Respond and resolve all Corr or other inquiries regarding a debt within timelines parameters</p> <p>c. Adjudicate and post checks received timely</p> <p>d. Review and respond timely to “Extended Repayment Plan” (ERP) requests and monitor ongoing ERPs</p> <p>e. Resolve all post demand 1870 waiver requests</p> <p>f. Validate debts using CWF and address all pending CORR specific to the debt prior to issuing the “Intent to Refer” (ITR) letter</p> <p>g. Issue ITRs to the appropriate individual or entity (includes the copy of initial demand package)</p> <p>h. Resolve all Treasury Action form requests</p> <p>i. Perform appropriate recall actions and update all internal systems to reflect the progression of the debt resolution (e.g MPARTS, DCS)</p> <p>j. Refer delinquent debts, as appropriate to Treasury</p> <p>k. Update all systems to reflect actions detailed on the Collections, Reconciliation/Acknowledgement form (CRAF)</p> <p>l. Perform appropriate debt related ECRS transactions (CWF assistance requests & ECRS inquiries). Use D in the ECRS AC field.</p> <p>m. Take appropriate referral actions for all compromise or waiver of interest requests</p> <p>n. Develop/complete write-off – closed recommendation reports</p> <p>o. Ensure all MSP report detail are available and complete and can support reported figures (i.e., MSP savings)</p>	<p>Workload 1 is the number of responses to initial demand letters received from the debtor /agent (i.e. checks and/or CORR).</p> <p>Workload 2 is the number of intent to refer to Treasury letters (ITRs) issued plus the number of responses received from ITRs (i.e., checks or CORR).</p> <p>Workload 3 is the number of actual referrals to Treasury plus the number of Treasury action forms received.</p>

FY 2005 Benefit Integrity Carrier Activity Dictionary

CAFM Code	Activity Name	Definitions	Tasks	Workload
23001	Medicare Fraud Information Specialist (MFIS)	<p>Costs associated with MFIS activity</p> <p>Reference:</p> <ul style="list-style-type: none"> PIM Chapter 4, section 4.2.2.5 – 4.2.2.5.2 <p>For specific references see the task list.</p>	<p>a. Obtains and shares information on health care issues/fraud investigations (PIM Chapter 4, section 4.2.2.5 – 4.2.2.5.2)</p> <p>b. Serves as a reference point for law enforcement and other organizations/agencies (PIM Chapter 4, section 4.2.2.5 – 4.2.2.5.2)</p> <p>c. Coordinates and attends fraud related meetings/conferences (PIM Chapter 4, section 4.2.2.5 – 4.2.2.5.2)</p> <p>d. Distributes Fraud Alerts and shares contractor findings on them (PIM Chapter 4, section 4.2.2.5 – 4.2.2.5.2 and Chapter 4, section 4.10.1 – 4.10.5)</p> <p>e. Works with CMS RO to develop and organize external programs and perform training (PIM Chapter 4, section 4.2.2.5 – 4.2.2.5.2)</p> <p>f. Serves as a resource for CMS as necessary (PIM Chapter 4, section 4.2.2.5 – 4.2.2.5.2)</p> <p>g. Helps develop fraud related outreach material (PIM Chapter 4, section 4.2.2.5 – 4.2.2.5.2)</p> <p>h. Assists in preparation and development of fraud related articles for contractor newsletters/bulletins (PIM Chapter 4, section 4.2.2.5 – 4.2.2.5.2)</p> <p>i. Serves as a resource for contractor training (PIM Chapter 4, section 4.2.2.5 – 4.2.2.5.2)</p> <p>j. Attends 32 hours of training sessions on training skills, presentation skills, and fraud related training (PIM Chapter 4, section 4.2.2.5 – 4.2.2.5.2)</p>	<p>Workload 1 is the number of fraud conferences/meetings coordinated by the MFIS.</p> <p>Workload 2 is the number of fraud conferences/meetings attended by the MFIS.</p> <p>Workload 3 is the number of presentations performed for law enforcement, ombudsmen, Harkin Grantees and other grantees, and other CMS health care partners.</p>

FY 2005 Benefit Integrity Carrier Activity Dictionary

CAFM Code	Activity Name	Definitions	Tasks	Workload
23004	Outreach and Training Activities	All costs associated with fraud, waste, and abuse outreach and training activities for contractor staff and beneficiaries. Include costs associated with establishing and maintaining fraud, waste, and abuse outreach and training activities for beneficiaries and providers (excluding MFIS activities)	<ul style="list-style-type: none"> a. Train non-BI staff on proper referral of complaints handled under BI (PIM Chapter 4, section 4.6.2) b. Initiates and maintains outreach activities with internal and external components as well as outside groups (PIM Chapter 4, section 4.2.2, 4.2.2.3.1, 4.4.3) c. Completion of required fraud training for BI staff (PIM Chapter 4, section 4.2.2.3) d. Provide law enforcement with training as needed (PIM Chapter 4, section 4.2.2.3.1) 	<p>Workload 1 is the number of training sessions (internal and external) furnished only to the BI staff.</p> <p>Workload 2 is the number of face-to-face presentations by BI unit staff made to beneficiaries and providers.</p> <p>Workload 3 is the number of training sessions furnished by the contractor BI unit to non-BI contractor staff.</p>
23005	Fraud Investigation Activities	Any costs associated with fraud investigation used to substantiate a case.	<ul style="list-style-type: none"> a. Identify program vulnerabilities (PIM Chapter 4, section 4.2.2.) b. Control, verify and document all investigations (PIM Chapter 4, section 4.2.2.4.1) c. Document all pertinent contacts, letters, decisions, discussions, etc. Retain records in accordance with the PIM (PIM Chapter 4, section 4.2.2.4.2) d. Interview providers and beneficiaries (PIM Chapter 4, section 4.7.1) e. Conduct onsite reviews (PIM Chapter 4, section 4.2.2.4). f. Determine patterns of fraud (PIM Chapter 4, section 4.2 and 4.2.2.4.1) g. Issue Fraud Alerts (PIM Chapter 4, section 4.10 – 4.10.5) h. Coordinate with Medical Review and other internal sources on fraud activities (PIM Chapter 4, section 4.2 and 4.3). i. Implement claim payment suspension (PIM Chapter 3, section 3.9 – 3.9.3.2) j. Determine exclusion action (PIM Chapter 4, section 4.19.2.2) k. Prioritization of investigations (PIM Chapter 4, section 4.2.2.1 and 4.7) 	<p>Workload 1 is the number of investigations opened.</p> <p>Workload 2 Of the investigations in workload column 1, report how many were opened by the contractor self-initiated proactive data analysis.</p> <p>Workload 3 is the total number of investigations closed (no longer requiring fraud investigation) and which did not become a case.</p>

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CAFM Code	Activity Name	Definitions	Tasks	Workload
23006	Law Enforcement Support	All BI costs and related data analysis for work done to support law enforcement	a. Receive and respond to all law enforcement requests (PIM Chapter 4, section 4.4.1)	<p>Workload 1 is the number of law enforcement requests.</p> <p>Workload 2 is the number of requests discussed with the RO.</p> <p>Workload 3 is the number of BI law enforcement requests that require data analysis.</p>
23007	Medical Review in Support of Benefit Integrity Activities	<p>All costs associated with medical review (MR) in support of BI activities. The main goal of medical review is to change provider-billing behavior through claims review and education; therefore, any BI initiated review activity that does not allow for provider education or feedback must also be charged to this activity.</p> <p>Reference:</p> <ul style="list-style-type: none"> • PIM Chapter 1, section 3, 3.2.4 	<p>a. Review of claims by MR and BI (PIM Chapter 4, section 4.3)</p> <p>b. Perform Statistical Sampling for overpayment estimation (PIM Chapter 3, section 8 ff)</p>	<p>Workload 1 is the number of cases in which the MR unit assisted the BI unit.</p> <p>Workload 2 is the number of claims reviewed by both the MR and BI unit for the BI unit.</p> <p>Workload 3 is the number of statistical sampling for overpayment estimation reviews performed by MR in support of BI.</p>
23014	Fraud Investigation Database (FID) Entries	All costs associated with FID entries	<p>a. Entering new investigations into the FID (PIM Chapter 4, section 4.11.2.2)</p> <p>b. Updating FID cases (PIM Chapter 4, section 4.11.2.5)</p> <p>c. Entering new payment suspension information (PIM Chapter 4, section 4.11.2.5)</p> <p>d. Updating payment suspension information (PIM Chapter 4, section 4.11.2.6)</p>	<p>Workload 1 is the total number of new cases entered and cases that were updated in the FID.</p> <p>Workload 2 is the total number of cases updated in the FID.</p> <p>Workload 3 is the total number of new payment suspensions entered into the FID.</p>

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CAFM Code	Activity Name	Definitions	Tasks	Workload
23015	Referrals to Law Enforcement	<p>All costs associated with referrals to law enforcement.</p> <p>Reference:</p> <ul style="list-style-type: none"> PIM 	<p>a. Developing the referral package to law enforcement (PIM Chapter 4, section 4.18.1.4)</p> <p>b. Fulfilling requests for additional information from law enforcement on the referrals they received (PIM Chapter 4, section 4.18.1)</p>	<p>Workload 1 is the total number of referrals to law enforcement.</p> <p>Workload 2 is the total number of law enforcement referrals requesting additional information by law enforcement.</p> <p>Workload 3 is the number of law enforcement referrals declined.</p>
23201	PSC Support Services	<p>The services that the AC will provide to support the BI activities being performed by the PSC (PIM)</p> <p>Misc. Codes:</p> <p>23201/01 ACs record the total costs associated with miscellaneous PSC support services (e.g., training and meetings).</p> <p>23201/02 ACs record the total costs associated with requests (not law enforcement requests) that they fulfill to support the PSC in investigations.</p> <p>23201/03 ACs record the total costs associated with PSC requests for support from the AC with law enforcement requests.</p>	<p>a. Perform training for the PSC (PIM Chapter 4, section 4.1)</p> <p>b. Conduct meetings in support of the PSC (PIM Chapter 4, section 4.1)</p> <p>c. Prepare/supply additional documentation at the request of the PSC (PIM Chapter 4, section 4.1)</p> <p>d. Install edits at the request of the PSC (PIM Chapter 4, section 4.1)</p>	<p>Workload 1 is the number of Miscellaneous PSC support services.</p> <p>Workload 2 is the number of requests (not law enforcement) to support the PSC in investigations.</p> <p>Workload 3 is the number of PSC requests for support from the AC with law enforcement requests.</p>

FY 2005 Local Provider Education & Training (LPET) Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
24116	One-on-One Provider Education.	<p>Contractors must initiate provider one-on-one education in response to medical review related coverage, coding billing problems identified, verified and prioritized through the analysis of information from various sources, including CERT and the medical review of claims. These educational contacts require clinical expertise and include face-to-face meetings, telephone conferences, or letters and electronic communications to a provider that address the provider's specific coding, coverage and billing issue. Included in this activity code are the costs and workload included in responding to provider questions concerning their specific medical review activities, or new or revised local policies.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM 100-8 Chapter 1, Section 5.1.1 • IOM 100-8 Chapter 11, Section 3.3.1 	<p>a. Analyze problem-specific data</p> <p>b. Determine appropriate educational method based on scope of problem</p> <p>c. Develop/produce educational information</p> <p>d. Deliver education</p>	<p>Workload 1 is the number of educational contacts.</p> <p>Workload 2 is the number of providers educated.</p>

FY 2005 Local Provider Education & Training (LPET) Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
24117	Education Delivered to a Group of Providers	<p>To remedy wide spread service-specific aberrancies, intermediaries may elect to educate a group of providers, rather than provide one-on-one contacts. Education delivered to a group of providers includes seminars, workshops, classes, and other face-to-face meetings to educate and train providers regarding Local Coverage Determinations (LCD), coverage, coding and billing considerations, and service or specialty specific issues. Clinical staff must be used as a resource.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM 100-8 Chapter 1, Section 5.1.2 • IOM 100-8 Chapter 11, Section 3.3.2 	<ul style="list-style-type: none"> a. Analyze Data b. Determine appropriate educational method based on scope of problem c. Gather resources, including clinical staff expertise, and develop/produce educational information d. Select focus groups or site visits/meetings. If feasible, collaborate with partner groups in holding events e. Hold educational meeting with the presence of clinical staff 	<p>Workload 1 is the number of educational activities.</p> <p>Workload 2 is the number of providers educated.</p>

FY 2005 Local Provider Education & Training (LPET) Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
24118	Education Delivered via Electronic or Paper Media	<p>Education delivered solely via paper media or electronically, without any live interactions is included here. Contractors are required to maintain a website and adhere to instruction regarding them (IOM 100-8 Chapter 1, Sec. 5.A.9). Examples of this type of education include, but are not limited to, the development and dissemination of frequently asked questions (FAQs), scripted response documents, bulletin articles, LCD postings, comparative billing reports (CBRs) issued for other than one-on-one provider education.</p> <p>Reference:</p> <ul style="list-style-type: none"> • IOM 100-8 Chapter 1, Section 5.1.3 • IOM 100-8 Chapter 11, Section 3.3.3 	<ul style="list-style-type: none"> a. Analyze problem-specific data b. Develop and disseminate web-based searchable FAQs c. Develop and disseminate bulletin articles d. Develop and disseminate CBRs e. Develop and disseminate other types of electronic or paper media education 	<p>Workload 1 is the number of educational documents developed for use in non-interactive educational interventions.</p> <p>Workload 2 is the number of CBRs developed (do not include CBRs developed for activities in 24116 and 24117).</p> <p>Workload 3 is the number of articles/advisories/bulletins developed.</p>

FY 2005 Provider Communication (PCOM – MIP) Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
25103	Create/Produce and Maintain Educational Bulletins	<p>All costs associated with the development, production and dissemination of provider bulletins/newsletters.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Section 30.1.5 	<p>a. Gather resources and information to use in developing bulletin</p> <p>b. Develop bulletin</p> <p>c. Publish bulletin</p> <p>d. Disseminate bulletin</p>	<p>Workload 1 is the total number of bulletin editions published.</p> <p>Workload 2 is the total number of bulletins mailed.</p>
25105	Partner with External Entities	<p>All costs associated with the establishment and maintenance of collaborative provider education efforts with external entities.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Section 30.1.12 	<p>a. Contact/communicate with external groups or organizations</p> <p>b. Work with external groups to foster and develop collaborative PET activities</p> <p>c. Obtain feedback on effectiveness and reach of partnering efforts</p>	<p>Workload 1 is the actual number of partnering activities or efforts with entities other than the PCOM Advisory Committee.</p>
25201	Administration and Management of PCOM Program	<p>All costs associated with administering and managing the provider communications program. Includes: analysis and identification of provider educational needs; planning of educational strategies, approaches, or efforts; training of staff in support education initiatives; and reporting of provider education activities and efforts.</p> <p>All costs associated with developing plans to outline the strategies, projected activities, efforts, and approaches that will be used in the forthcoming year to support physician/supplier education and training.</p>	<p>a. Develop and submit PSP Report</p> <p>b. Develop and submit Quarterly Activity Reports</p> <p>c. Develop and maintain a provider inquiry analysis program</p> <p>d. Tally and analyze claim submission errors</p> <p>e. Solicit and analyze provider feedback</p> <p>f. Development and research responses to provider referrals of provider inquiries</p> <p>g. Hold periodic meetings with other contractor staff to ensure that issues raised by providers are being addressed through education</p> <p>h. Send at least one training representative to between 2-4 CMS-sponsored training events</p>	<p>Workload 1 is the number of provider inquiries referred to the provider communications area requiring technical experience, knowledge or research to answer.</p>

FY 2005 Provider Communication (PCOM – MIP) Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		Reference: <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Sections 30.1.1,2,3,10,11 & 20.2.1 		
25202	Develop Provider Supplier Education Materials and Information	<p>All costs associated with the planning, design, research, writing and development of materials and information used to support provider education and training efforts. This includes work for new as well as substantially revised materials or information. (These materials do not include bulletins and newsletters.)</p> <p>Misc. Code: 25202/01 - Special Media for costs associated with preparation of special media.</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Sections 30.1.14 	<p>a. Plan materials b. Research needed information c. Design, layout materials d. Write, illustrate or revise material e. Duplicate materials f. Prepare special media educational presentations (discretionary)</p>	<p>Workload 1 is the number of special media efforts developed.</p>
25203	Disseminate Provider Information	<p>All costs associated with holding workshops seminars, classes and other provider education events or face-to-face meetings. (Does NOT include activities related to creation of bulletins or newsletters.)</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Sections 30.1.6,8,9,13. 	<p>a. Hold workshops, seminars, classes and other face-to-face meetings b. Disseminate Medicare provider information or materials at other provider education events or opportunities</p>	<p>Workload 1 is the number of educational seminars, workshops, classes and face-to-face meetings held.</p> <p>Workload 2 is the number of attendees at your educational seminars, workshops, classes and face-to-face training.</p>

FY 2005 Provider Communication (PCOM – MIP) Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
25204	Management and Operation of PCOM Advisory Group	<p>All costs associated with the management and operation of the PCOM Advisory Group (formerly the PET Advisory Group).</p> <p>Reference:</p> <ul style="list-style-type: none"> IOM, Pub.100-09, Chapter 4, Sections 30.1.4 	<p>a. Arrange PCOM Advisory Group meetings</p> <p>b. Solicit and maintain membership</p> <p>c. Obtain materials, supplies and equipment for meetings</p> <p>d. Produce and distribute PCOM Advisory Group information (agenda, minutes, etc.)</p>	